CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555827	A. BUILDING _____ B. WING _____	12/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATHERTON HEALTHCARE	1275 CRANE STREET, MENLO PARK, CA 94025 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit. Representing the Department of Public Health: [redacted], HFEN CLASS AA CITATION -- PATIENT CARE 22-1762-0005030-S Complaint(s): CA00133222 Title 22 72311(a)(1)(A)(C) -- Nursing Service - General (a) Nursing service shall include, but not be limited to, the following: (1) Planning of patient care, which shall include at least the following: (A) Identification of care needs based upon an initial written and continuing assessment of the patient's needs with input, as necessary, from health professionals involved in the care of the patient. Initial assessments shall commence at the time of admission of the patient and be completed within seven days after admission. (C) Reviewing, evaluating and updating of the patient care plan as necessary by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition. Health & Safety Code Section 1418.6 Section 1418.6 - No long term health care facility shall accept or retain any patient for whom it cannot provide adequate care.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555827	A. BUILDING _____ B. WING _____	12/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATHERTON HEALTHCARE	1275 CRANE STREET, MENLO PARK, CA 94025 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 1 The regulations were not met as evidenced by: The facility failed to consistently assess, evaluate, and update the resident's care plan who was identified with history of falls. Resident 1 had 14 episodes of falls and sustained injuries such as: lacerated wound on the nose, chin, lower lip, back, right side of head and bruise to left upper and lower eyelid. On 11/24/07 the resident was noted to have a laceration on the right side of the head. Resident 1 was transferred to the hospital and the CT scan showed hematoma, (swelling filled with blood in the brain resulting from a break in a blood vessel) acute cerebral herniation, (protrusion through a ruptured brain wall) and 3 cm. right parietal laceration. The resident was unresponsive and was admitted to the hospital. Resident 1 was admitted to the facility on 12/18/06 with diagnosis of Huntington's disease (slow progressive mental decline with bizarre involuntary movements). The resident was identified during admission as high risk for falls and potential for injury related to unsteady gait. Minimum Data Set Quarterly Assessment (MDS-an assessment tool) dated 9/24/07 indicated that the resident had short and long term memory problems. Resident 1 required supervision for daily decision making, required supervision and limited to total assistance with her activity of daily living such as bathing, dressing, grooming, and eating. Review of the care plan on 2/9/07 through 11/24/07 showed that Resident 1 was a "Potential for injury			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555827	A. BUILDING _____ B. WING _____	12/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATHERTON HEALTHCARE	1275 CRANE STREET, MENLO PARK, CA 94025 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 2 due to unsteady gait related to Huntington's disease, cognitive deficits, safety awareness impaired, poor motor control, use of psychotropic, and history of falls ". The care plan interventions (approaches) were as follows: " Provide safe environment at all times, remind resident to call when needing assistance, educate resident in safety awareness, keep call light and most frequently used personal items within reach, monitor for delayed pain or injury and report to MD, assist resident with transfer and ambulation, fall precaution maintained for safety awareness ". The Nursing notes had documentation of incidents of falls between 2/09/07 to 11/24/07: "2/9/07-Fell in her room and sustained a lacerated wound on her forehead about 0.2 cm. x 2.0 cm. 2/12/07-Unwitnessed fall and sustained a lacerated wound on her left eyebrow about .5 cm. 2/17/07-Found sitting on the floor with a bump on her forehead. 3/25/07-Fell down on her behind, no apparent complain of pain or discomfort. 4/6/07-Unwitnessed fall, found resident sitting in the bathtub, no injury. 4/21/07-Found sitting on the floor and sustained a bruised, swollen left upper and lower eyelid. 4/25/07-Found the resident in bed with open wound on her lower lip. 5/28/07- Found the resident sitting on the floor next to bathroom, no injury. 6/17/07- Unwitnessed fall, found the resident sitting in bed with open wound on her nose from hitting the siderails. 7/2/07-Resident fell down after she spilled the water			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555827	A. BUILDING _____ B. WING _____	12/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATHERTON HEALTHCARE	1275 CRANE STREET, MENLO PARK, CA 94025 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 3 pitcher on the floor, no injury. 7/29/07- Unwitnessed fall, found the resident sitting in her bed with a laceration on the chin about 3 cm. in length and 2 cm. in depth. Resident 1 got transferred to acute care and had medical glue to hold the wound. 9/16/07-Fell in her room and sustained a laceration on right eyebrow about 12.0 cm. in length and she was transferred to acute care for suturing. 10/1/07-Found lying in the bathroom with open wound on her head (occipital area). 11/24/07-Unwitnessed fall, the CNA while combing resident's hair, she noticed a deep lacerated wound on the resident's right side of head about 2.0 cm. in length x 0.3 cm. in depth". The licensed staff informed the physician but the physician didn't think that it was necessary to transfer the resident to acute care for suturing. The physician's statement indicated in the nurse's notes dated 11/24/07 at 1:00 P.M., stated that "she does not need to be sent out for stitches because scalp wounds heal easily ". The licensed staff informed the alternate physician and Resident 1 was transferred to acute care emergency room on 11/24/07 at 4:25 P.M. Review of the clinical records from the acute care hospital showed that Resident 1 was admitted on 11/24/07, unresponsive and was in critical condition. Her blood pressure was elevated at 195/120 and a heart rate of 128/ minute. A head CT (computerized tomography) scan was obtained which confirmed a left subdural hematoma, measuring 17 mm. maximum width, cerebral herniation and right parietal laceration. A case			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555827	A. BUILDING _____ B. WING _____	12/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATHERTON HEALTHCARE	1275 CRANE STREET, MENLO PARK, CA 94025 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 4 conference led by the attending physician held on 11/28/07 had recommendations that the resident be placed on comfort care and a long term placement. The plan was discussed with the family who agreed with the plan. The family did not want the resident to return to the facility. Resident 1 was transferred to facility 2 on 11/30/07 at 1:25 P.M. for comfort care and died on 12/1/07 at 12:05 P.M. In an interview on 12/11/07 at 9:50 A.M., the administrator stated, "We tried everything to prevent the resident from falling and she was a very difficult patient, we cannot tie her due to Huntington's disease ". The Coroner's summary report dated 12/1/07 stated, " The subject is a 48 year-old female with a history of degenerative Huntington's chorea disease who suffered an unwitnessed fall causing left-sided subdural hematoma with midline shift, cause of death, " bilateral subdural hemorrhages due to blunt head trauma ". The facility failed to identify and continuously assess, evaluate and update the resident's needs and plan of care to prevent further falls and injuries resulting in an unplanned hospitalization because of acute left subdural hematoma, (swelling filled with blood in the brain resulting from a break in a blood vessel), acute cerebral herniation (protrusion through a ruptured brain wall), and 3 cm. right parietal laceration. Resident 1 died on 12/1/07. The above violation presented an imminent danger to the patient and was a direct proximate cause of			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555827	A. BUILDING _____ B. WING _____	12/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATHERTON HEALTHCARE	1275 CRANE STREET, MENLO PARK, CA 94025 SAN MATEO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 5 the death of the patient.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.